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NEWS NOTES

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GENERAL BLISS REPORTS ON HEALTH OF EUROPEAN ARMY

Brigadier General Raymond W. Bliss, The Deputy Surgeon General, who recently returned from a visit to the European Theater, reported on "the overall excellence of the medical service" provided by American Army doctors in Germany, France and Italy.

Commanding Generals of headquarters, without exception, expressed their appreciation of the quality of the medical officers in their commands, and the services rendered by them, according to General Bliss.

"During the war the Medical Corps was more of a cross-section of mature American medicine;" General Bliss said. "Today the cross-section is of recent graduates in medicine who have completed their internships and varying degrees of medical and surgical residencies. These younger doctors are well trained, alert, energetic, careful in their examination of patients and thoroughly interested in their work. Patient care is on a high level and compares favorably with the highest standards of American medical practice. They are to be congratulated, and American medicine has every reason to be proud of them and of the excellence of current medical education. American families may be assured unhesitatingly that every patient in the hospitals in this Theater is receiving careful, conscientious and efficient medical care.

"There is at present a great opportunity in contemporary German medicine for young medical officers to increase their knowledge. There is an enormous amount of clinical material available for study and the more studious and alert will seek ways and means of using this opportunity to the best advantage.

"Dental service in all hospitals was adequate and satisfactory.

"As always the nurses are performing their duties conscientiously. Very generally the morale of the nurses is high - their quarters are superior."

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GENERAL BLISS REPORTS ON HEALTH OF EUROPEAN ARMY (Cont'd)

The remarkable and consistently low non-effective rate, i.e. an average of 2.3% absent from duty in hospital or quarters for the last ten months, is evidence of the general effectiveness of disease and injury control and treatment, according to General Bliss. However, the rate of incidence of the following preventable condition is unduly high:-

a. Venereal diseases.

b. Certain skin diseases.

c. Injuries.

The entire command is acutely conscious of the high incidence rate of these conditions and preventive measures are being intelligently instituted. The acquisition of venereal disease infection in mature individuals whose intelligence has not been blunted by alcohol is relatively small. The elimination of the unintelligent now in progress, the most careful supervision of the immature by conscientious and well indoctrinated noncommissioned and company grade officers, the careful treatment of known infected civilians and the application of all the ancillary spiritual, educational and recreational aids, should eventually reduce the venereal disease incidence materially.

These skin conditions are common among the crowded German civilian population.

"In the Public Health measures instituted by the Military Government," he said, "none is more important in its beneficial relations with disease incidence in the Army than the continued use by the German civilian population of penicillin. Its results, after a year of most intensive procedural indoctrination, are just becoming apparent and its use is presently abruptly discontinued because of lack of penicillin by the American Military Government."

IMPROVED ARTIFICIAL HAND ANNOUNCED

A new artificial hand which represents a major advance in the manufacture of prostheses for amputees was announced by Major General Norman T. Kirk, The Surgeon General of the Army.

Both cosmetically and mechanically this hand is far superior to anything that has been perfected to date, according to Major Maurice J. Fletcher, Director of the Prosthetics Laboratory of the Army Medical Center which developed the hand.

The "hook" hand at present is the best that can be provided from a utility standpoint. In this new advance the hand operates more effectively for the amputee and in addition it has the appearance of a natural hand.

In making this announcement General Kirk emphasized that those devices are not on the market now and will not be until civilian industry gets them into production.

The life-like appearance of the glove, which is part of this new hand, is of tremendous value to the morale and psychological well-being of an arm amputee, according to Brigadier General George C. Beach, Jr., Commanding General of the Army Medical Center.

The Army Laboratory has produced a glove of plastic material, simulating a natural hand, even to the finger prints, skin structure and hair. It is seamless, flexible, and of light weight, is less inflammable than clothing and waterproof. The careful compounding of the materials used has resulted in a glove of greater resistance to the deterioriating effects of the atmosphere and chemical reagents encountered by a hand in normal use.

The development of the hand through its progressive stages has resulted in a series of new components, each adaptable to a different combination to provide a number of finger and hand movements covering a wide range of utility in a completed hand.

This hand is designed to impart all of the force from the controlling means into the first and second fingers, which meet conjointly with the thumb. A force amplifier is built into the hand, which transmutes the initial impulse and compensates for mechanical losses, thus giving the amputee a greater grip at the fingertips for each one-pound of force exerted on the control cable than he has ever been able to with any other artificial hand -- a tremendous advantage over any existing prosthesis.

Cosmetic hands now in use produce only about 4 pounds of grip for 15 pounds of pressure. This new hand gives about one pound of grip for one pound of pressure.

Pressure at the fingertip has been one of the outstanding problems in prosthetic manufacture since the inception of artificial hands, and through the development of this efficient, simple force amplifier, the problem now becomes one of limiting the amount of fingertip pressure within controllable bounds.

Sensitivity as to the strength of the hand is achieved far more efficiently and positively than in any of the hands produced in the past; it is of great benefit to be able to gauge the potentiality of the applied force.

The first and second fingers are equalized to assure a strong grip on objects grasped between the thumb and the fingers, providing in normal use and over normal contours the exertion of pressure from three points -- this three point contact prevents twisting or slipping of an object grasped.

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The third andfourth fingers of the hand would ordinarily add little to the value of a mechanical grasp, and are therefore designed only for prolonged strain in carrying a handled object, such as a suitcase. These fingers can also be used as a control lever for locking and unlocking the movable fingers.

Two miniature clutches of great strength, capable of releasing easily under full pressure, are used in the hand. One is used to pre-position the thumb, permitting a wide latitude in the size of the object grasped. This positioning can be made without awkward movements or strained unnatural contortions and can be released in the same manner by a simple rolling motion against one of the clutches. The other clutch is used when wanted to lock the fingers in a position or grip desired by the amputee to relieve strain on the controlling means.

The weight of the glove is between two and three ounces, and the proposed completed hand will weigh approximately twelve ounces. The objective to be attained was that the hand perform as many functions of normal living as possible, without involving a high degree of complexity, weight, or need for prolonged training in its use.

DIETITIANS NEEDED NOW BY ARMY

The immediate need for 50 additional Medical Department dietitians for assignment to Army hospitals in the United States and overseas was announced recently by the War Department.

Initial appointments are made in the grade of second lieutenant and for the period of the Emergency and six months thereafter unless sooner terminated. The salary is $2,160 per year. In addition, 70 cents per day subsistence allowance and quarters are provided. There is a 5 per cent increase in base pay for every 3 years of service. A 10 per cent increase in base pay is authorized for duty beyond the continental limits of the United States.

Applicants must be unmarried. Citizens of the United States, Philippine Islands or other friendly country, who are otherwise qualified, are eligible for appointment. Naturalized citizens must furnish a notarized or certified statement of citizenship with the applications.

A final type physical examination by a board of medical officers is required. An applicant who meets the educational, citizenship and age requirements will be authorized to report (travel at her own expense) at a designated Army post for a physical examination.

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DIETITIANS NEEDED NOW BY ARMY (Cont'd)

The applicant must have a degree from an approved college with a major in either foods and nutrition or institution management. She must also have completed a dietitians' training course approved by The Surgeon General. Two years experience in a hospital approved by The Surgeon General may be substituted for the training course, provided the experience includes diet therapy, planning adequate menus, supervising employees in food preparation and service, food cost control, and ordering food supplies and equipment. One year of this experience must have been within the last 10 years. Proof of education and outline of experience, if used in lieu of approved course, should be submitted with the applications unless the institution desires to forward it direct to The Surgeon General's Office.

Medical Department dietitians are women members of the Medical Department, with commissioned officer status in the Army of the United States. There are 400 Medical Department dietitians now on duty.

The duties of the Medical Department dietitians are the planning of all menus for patients, the requisitioning through the mess officer of all food supplies and equipment, the supervision of preparation and serving of food to patients, the instruction of patients in diet, assistance in the supervision of mess sanitation, and the maintenance of accounts and records pertaining to the duties of the dietitian.

Application should be made to The Surgeon General, Attention: Dietetic Consultants Division, Pentagon Building, Washington 25, D. C.

AURAL REHABILITATION CENTER AT W.R.G.H.

Major General Norman T. Kirk, The Surgeon General, in dedicating the Walter Reed General Hospital Aural Rehabilitation Center at Forest Glen, Md., on January 19 said that the hard-of-hearing will receive care here "of the most modern kind known to science."

"The construction of this Center," General Kirk said, "with its facilities and the personnel who have been ordered here to operate it, represents the accummulative knowledge of the advances that have been made during this war in the care of the hard-of-hearing. The testing and training equipment has been expertly developed and constructed by acoustical engineers. Much of the equipment which is being used and which you will see this afternoon has been designed with the help of the National Research Council in cooperation with the Central Institute for the Deaf in St. Louis, and the Psycho-acoustic Institute at Harvard. Some of the other equipment was developed by the excellent personnel who served in the Army in these three Aural Rehabilitation Centers during the war period. Talents and skills of a wide variety have contributed to this team. The staff assembled for the present work here at Forest Glen includes otologist, psycho-acoustic specialists and technicians, lip-reading and speech-correction instructors, and electronic engineers, as well as occupational therapists and other personnel that go to make up a hospital.

"The transparent plastic ear inserts or molds of the ear canal are made from an impression of each patient's own ear canal. This development assists materially in assuring the proper fit of the insert, lessening the "feed-back" squeal or noise which sometimes would otherwise occur. The Dental Corps and technicians trained by them initiated the manufacture of these molds in each of the Army's Aural Rehabilitation Centers.

"Each patient is critically examined to determine the type of hearing loss from which he is suffering, audiometer readings are made to determine the extent of that loss, and various types of hearing aids are tested to determine which type is best for the individual patient. It has been estimated that there are several hundred different hearing aid prescriptions possible for a given individual, due to the various combinations of microphones, amplifiers, receivers, and batteries. These are thoroughly explored in each individual case.

"During hospitalization the patient is given the maximum benefits of medical and surgical treatment. Testing, teaching, and training the patient requires six to eight weeks to assure the proper selection and the best use of the hearing aid and to rehabilitate him. Lip-reading and speech correction are parts of this training program. Psychological tests are given to determine the emotional status, mental capacity, and vocational inclination of each individual.

"A questionnaire which was sent to the "graduates" of the Army's Aural Rehabilitation Centers revealed that 94% were satisfied with their hearing aids which had been issued; yet previous surveys, among civilians who at one time or another purchased a hearing aid, showed that 75% of them had discarded their hearing aid which they, themselves had purchased.

"I want to take this opportunity to congratulate and thank those working in my office, and particularly these specialized Centers, for the splendid work all have done in the care of the hard-of-hearing in the Army."

The Army program for the treatment of the hard-of-hearing, which was carried on in such a splendid fashion during the war period, was first initiated in July 1943 at Walter Reed General Hospital. It was soon found that there were too many specialities centered in this institution and in November of that year this center, with its personnel, was moved to Deshon General Hospital at Butler, Pennsylvania. Two other Aural Rehabilitation Centers were later established, one at Borden General Hospital, Chickasha, Oklahoma, and the other at Hoff General Hospital, Santa Barbara, California. The Navy, likewise, established Aural Rehabilitation Centers in certain of their general hospitals. Undoubtedly, greater developments were made during the war years, as a result of the Armed Forces Aural Rehabilitation

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AURAL REHABILITATION CENTER AT W.R.G.H. (Cont'd)

Program for the mass care of the hard-of-hearing, than were ever made before. Some 8400 patients have received special treatment for impaired hearing in these three Army Aural Rehabilitation Centers.

With the decrease in the patient load, the Medical Department has closed 54 general and 12 convalescent hospitals. When these were closed the three Aural Rehabilitation Centers were wiped out. The Army is at present operating one convalescent and 14 general hospitals. For these reasons the Aural Rehabilitation Center was again established at Walter Reed. This is where the Army will now give care to the hard-of-hearing, both for Army personnel and for Veterans Administration beneficiaries.

MEDICAL DEPARTMENT OFFICERS INTEGRATED INTO REGULAR ARMY

Appointment of Medical Department officers in the Regular Army has been announced by the War Department in the first selection to be made under the Regular Army Integration Program during 1947. The grade given each officer in the following list is his permanent grade in the Regular Army. His grade in the Army of the United States, National Guard or Officers Reserve Corps appears in parentheses.

Capt. (Maj.) Robert B. Dickerson, MC, 2882 Monroe St., San Diego, Calif.
Maj. (Maj.) Francis J. Aldwin, MC, 185 Crown St. Meriden, Conn.
Maj. (Lt.Col.) Harold A. Conrad, MC, Box 2, Station Hospital, Fort Knox, Ky.
Maj. (Maj.) Joseph W. Iseman, MC, 356 Pleasantview Drive, Battle Creek, Mich.
Capt. (Maj.) John Rizzolo, MC, 181 Mt. Prospect Ave., Newark, N.J.
Maj. (Lt.Col.) Francis S. Crane, MC, Wilburton, Okla.
Maj. (Lt.Col.) Irvine H. Marshall, MC, 719 Ferree St., Coraopolis, Pa.
Capt. (Maj.) Benjamin P. Clark, MC, 702 E. 20th St., Sioux Falls, S. Dak.
Capt. (Lt.Col.) August R. Huberwald, DC, 1333 Webster St., New Orleans, La.
Capt. (Capt.) Thomas A. Egan, DC, 1308 West 2nd Street, McCook, Nebraska
Maj. (Maj.) Edward R. Dixon, DC, 935 East End Avenue, Pittsburgh, Pa.
Capt. (Lt.Col.) Clinton L. Gould, VC, 912 K St., Eureka, Calif.
Capt. (Capt.) Daniel P. Sasmore, VC, Box 2249, Rio Linda, Calif.
Capt. (Maj.) Nels F. Christensen, VC, 2225 Iowa St., Cedar Falls, Iowa
Capt. (Capt.) Jack H. Hempy, VC c/o Dr. W.B. Hempy, Groveport, Ohio
1st Lt. (Capt.) Henry M. Miller, VC, 33 South Quentin Avenue, Dayton, Ohio
Capt. (Capt.) Ralph D. Walters, VC, 47 West 10th Avenue, Columbus, Ohio
Capt. (Maj.) Conley G. Isenberg, VC, Chandler, Okla.
Capt. (Maj.) Frank J. Davies, VC, 215 Yale Avenue, Swarthmore, Pa.
Capt. (Capt.) John H. Harrison, VC, RFD #4, New Castle, Pa.
Capt. (Maj.) Everett B. Miller, VC, 314 N. 14th Street, Allentown, Pa.
1st Lt. (Capt.) William G. Brooks, VC, Route 3, Jefferson, Texas
Capt. (Lt.Col) Seidel M. Stephens, VC, 455 Galveston, Fort Worth, Texas
1st Lt. (1st Lt.) R. S. LaFrankie, PhC, 4512 Third Ave., Los Angeles, Calif.

MORE

MEDICAL DEPARTMENT OFFICERS INTEGRATED INTO REGULAR ARMY (Cont'd)

1st Lt. (Capt.) Joseph M. Normington, PhC, 4010 Sacramento Blvd., Sacramento, Calif.
1st Lt. (Capt.) Bertram S. Wright, PhC, Rt. 6, Box 3921, Sacramento, Calif.
1st Lt. (Maj.) Harold E. Hill, PhC, Woodland Park, Colo.
1st Lt. (Capt.) Edward C. Knoblock, PhC, Box 255, Gunnison, Colo.
Capt. (Lt.Col.) Thomas A. Carilia, PhC, 43 Pardee Place, New Haven, Conn.
Capt. (Lt.Col.) George T. O'Reilly, PhC, 109 Church St., Wallingford, Conn.
1st Lt. (Capt.) Charles E. Goings, Jr., PhC, 4616 S. Dakota Ave., N.E. Dist. of Columbia
1st Lt. (Capt.) Howard C. Hensley, Jr. PhC, 4008 Suwannee Ave., Tampa, Fla.
1st Lt. (Capt.) Douglass V. Lord, PhC, Thomaston, Ga.
Maj. (Lt.Col.) John G. Morris, Jr., PhC, 842 Dalney Street, N.W. Atlanta, Ga.
1st Lt. (Capt.) Henry L. Wamble, PhC., RFD #1, Cairo, Georgia
1st Lt. (Maj.) Raymond J. Caldbeck, PhC, 1442 N. Dearborn Pkwy, Chicago, Ill.
2nd Lt. (2nd Lt.) Carroll E. Clutter, PhC, R.R. #2, Cisne, Ill.
Capt. (Maj.) Samuel P. Haykin, PhC, 1011 East Elm St., Taylorville, Ill.
Capt. (Maj.) Richard L. Offutt, PhC, 1020 Lawrence Avenue, Chicago, Ill.
1st Lt. (1st Lt.) Glen M. Walsh, PhC, 503 Second St., c/o James Walsh, Harvard, Ill.
Capt. (Capt.) Walter D. Correll, PhC, 1420 Grand Avenue, Davenport, Iowa
1st Lt. (1st Lt.) Melvin F. Cunningham, PhC, 326 Genesee St., Storm Lake, Iowa.
1st Lt. (Capt.) Austin S. Hall, PhC, 1006 Pearl St., Grinnell, Iowa
Maj. (Col.) Dale L. Thompson, PhC, 402 East Oak Street, Centerville, Iowa
1st Lt. (Capt.) Howard J. Funston, PhC, c/o John I. Funston, 810 N. Green St., Henderson, Ky.
Capt. (Capt.) Victor B. Taylor, PhC, Route #3, Owensboro, Ky.
Capt. (Capt.) Donald W. Worthen, PhC, Guilford, Maine
2nd Lt. (1st Lt.) Lynn R. Cheezum, PhC, Denton, Maryland
1st Lt. (Capt.) Robert L. Hughes, Jr., PhC, Perryman Road, RD #1, Aberdeen, Md.
1st Lt. (Capt.) F.E. Van Sickle, Jr., PhC, Med. Div. Bldg. 355, Edgewood Arsenal, Md.
Capt. (Capt.) Bertrand N. Beaudet, PhC, 174 Pleasant St. Gardner, Mass.
Capt. (Maj.) Renaldo G. Belanger, PhC, 142 Tuttle St., Fall River, Mass.
Capt. (Capt.) John W. Loney, Jr., PhC, 153 Spring Street, Brockton, Mass.
1st Lt. (Capt.) Edward Marks, PhC, 51 Esmond Street, Dorchester, Mass.
1st Lt. (Capt.) William C. Blamer, PhC, 29 1/2 Pontiac Street, Oxford, Mich.
1st Lt. (Capt.) Russell E. Horton, PhC, Box 185, South Lyon, Mich.
1st Lt. (Capt.) Max E. Knickerbocker, PhC, c/o Mrs. Mable Knickerbocker, Pinconning, Mich.

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MEDICAL DEPARTMENT OFFICERS INTEGRATED INTO REGULAR ARMY (Cont'd)

Maj. (Maj.) Reginald R. Quarton, PhC, 430 Lincoln Road, Grosse Pointe, Mich.
1st Lt. (Capt.) Norman S. Drowns, PhC, 727 East Lake Boulevard, Rt #5, St. Joseph, Missouri
1st Lt. (Capt.) Richard M. Stacey, PhC, 948 Twining Place, Webster Grove, Mo.
1st Lt. (1st Lt.) John H. Wrigley, PhC, 930 So. Washington St., Independence, Mo.
Capt. (Maj.) Alfred C. Strode, PhC, 201 South Avenue West, Missoula, Mont.
Maj. (Maj.) Harold V. Taylor, PhC, 1539 D Street, Lincoln, Nebraska
Capt. (Maj.) Joseph Di Giacoma, PhC, c/o Mrs. J. Fernicola, 597 Parker St., Neward, N.J.
Maj. (Maj.) Russel Murray, Jr., PhC, Rome, New York
1st Lt. (Capt.) Paul H. Myers, PhC, 137 S. Lake Ave., Albany, N.Y.
Capt. (Capt.) Herbert G. Richek, PhC, 215 E. 197th St., New York, N.Y.
Maj. (Maj.) David C. Burke, PhC, 1870 North Fourth Street, Columbus, Ohio
1st Lt. (Capt.) John J. McGovern, PhC, 21 South Wright Avenue, Osborn, Ohio
1st Lt. (1st Lt.) William S. Hench, Jr., PhC, 807 Green Street, Harrisburg, Pa.
1st Lt. (Maj.) Edward J. Martin, PhC, 5008 Roosevelt Blvd., Philadelphia, Pa.
1st Lt. (Capt.) Alonzo R. Williams, PhC, 49 East Kirmar Ave., Alden Station, Nanticoke, Pa.
1st Lt. (Capt.) John W. Holt, PhC, 45 Broad St., Charleston, S. Carolina
Capt. (Lt.Col.) Clarence V. Frey, PhC, 2204 Baldwin St., Houston, Texas
1st Lt. (Capt.) George L. Hahn, PhC, Box 143 London, Texas
Capt. (Capt.) Hubert S. Kirksey, PhC, General Delivery, Conroe, Texas
Capt. (Lt.Col.) Rahe A. Miller, PhC, 1186 S. 5th St., E., Salt Lake City, Utah
Capt. (Capt.) Francis M. Lunnie, PhC, Concord, Vermont
Capt. (Maj.) Oscar H. Adams, PhC, 313 Jefferson St., Lexington, Va.
Capt. (Capt.) Vernon E. Blythe, PhC, Box 131, Arlington, Va.
Maj. (Lt.Col.) Robert M. Bynum, Jr., PhC, 4337 S. 36th St., Arlington, Va.
1st Lt. (Maj.) Andrew J. Colyer, PhC, 1015 N. Kensington St., Apt. 2, Arlington, Va.
Capt. (Maj.) John F. Doyle, PhC, 5121 25th St., N., Arlington, Va.
1st Lt. (Lt.Col.) Ernest W. Wilson, PhC, 3244 Martha Custis Dr., Alexandria, Va.
1st Lt. (1st Lt.) Benjamin F. Lambert, PhC, 3604 McCorriston St., Honolulu, T.H.
Capt. (Lt.Col.) Tolbert H. Belcher, PhC, #23 Eastwood Ave. & 15th St. Tuscaloosa, Alabama
1st Lt. (Capt.) Chester C. Holloman, PhC, 1611 N. Main St., North Little Rock, Arkansas

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VETERINARY REPORT REFLECTS BENEFITS OF ARMY FOOD INSPECTION PROGRAM

The effectiveness of the Army Veterinary Corps food inspection program is attested by the fact that no serious, widespread outbreak of disease traceable to the issue of unwholesome meat, meat-food and dairy products has occurred among United States Army troops in the past several years, Colonel James A. McCallam, Chief, Veterinary Consultants Division, Office of The Surgeon General, stated recently.

The Veterinary Corps in a report for 1946 announced that it inspected and passed, at time of procurement by the Government, 1,368,412,978 pounds of foods of animal origin. 40,042,009 pounds of foods of animal origin were inspected and rejected at time of procurement for non-compliance with type, class or grade, and 6,180,674 pounds of foods of animal origin were inspected and rejected at time of procurement as being insanitary or unsound.

These totals include inspections made for the Navy, Marine Corps, Coast Guard and War Shipping Administration, but do not include the billions of pounds of government-owned foods re-inspected in storage, during shipment, and at time of issue.

A great saving is also made for the Government by the careful repeated inspections by the Army Veterinary Service on the vast stores of perishable as well as canned foods held in storage by the Government, to detect early deterioration or improper storage conditions, thereby making it possible to take corrective action and economically dispose of foods before spoilage occurs. This has been of paramount importance in overseas theaters where during 1946 millions of pounds of foods were still in storage following the end of the war.

DR. MENNINGER DISCUSSES NEUROPSYCHIATRY IN THE ARMY

Dr. William C. Menninger, former wartime Chief of the Neuropsychiatric Consultants Division of the Army, in a press conference following the meeting of the Civilian Neuropsychiatric Consultants to the Secretary of War held in the Office of The Surgeon General on January 20 - 21, discussed the progress of military neuropsychiatry during the war, and pointed out some of the problems encountered by which the resulting experience gained would enable a better handling of both a peacetime and any future mobilized Army. Dr. Menninger stressed the importance of good leadership, proper motivation and identification of the individual with his unit for the maintenance of good mental health of the soldier. He also emphasized the necessity of early recognition of the factors and symptoms leading up to the soldier's neuropsychiatric breakdown which would prevent the potential mental casualty.

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MEDICAL DEPARTMENT EXHIBIT DISPLAYED IN PENTAGON

The Army Medical Department Exhibit depicting modern methods in military medicine in World War II will be displayed in the Concourse of the Pentagon Building beginning February 10. The exhibit has been at the Smithsonian Institution during the past month.

VETERINARY SERVICE FOR THE K-9 CORPS

The Veterinary Corps, United States Army, played a very vital role in maintaining the health and efficiency of all war dogs used in World War II. In connection with this important function of the Veterinary Service, a war dog with three years service, one year during which he saw duty as a scout dog, has been included as a part of the Veterinary Section of the Medical Department Exhibit. This exhibit has been displayed in the National Museum of the Natural History Building, Smithsonian Institution, Washington, D.C., since 6 January 1947. It is planned to move the exhibit, intact, from Smithsonian Institution, to the Pentagon Building Concourse, where it will be displayed for one month, beginning on 6 February.

Eighteen-thousand (18,000) dogs were acquired for the Army during World War II by the Remount Branch of the QMC which gave them basic training and issued them to the troops. Prior to that time, dogs had not been included in an official War Department activity and, therefore, none had been acquired by the Army. Consequently, there were many problems incident to the establishment. Among these problems may be listed such as supply and equipment for care and handling of dogs, training of war dog handlers, shelter, transportation, size, types, and use of various types, of war dog units, prevention and control of infectious and communicable diseases incident to assembling dogs in large numbers, shipment, and subsequent use in foreign countries, where many canine diseases are prevalent which are not indigenous to the United States. During World War II, war dogs were used for many purposes, chief among which were: sentry, attack, and scouting duties.

Germany had used dogs extensively in World War I and continued to build her "dog Army" until she had fifty-thousand (50,000) trained dogs on duty when World War II started. Germany gave Japan ten-thousand (10,000) trained dogs during the recent conflict, which Japan used in the China, Burma, and Pacific campaigns. Russia and England also used war dogs in large numbers. Their role was varied. The use of war dogs by the enemy was first observed in the desert warfare in North Africa, when the enemy employed dogs to point out our concealed machine gun positions and outposts. They were also used to carry light ammunition, machine guns, as sled dogs, first aid dogs, wire laying, guard, mine detecting dogs, for detecting chemical agents, as messengers, and as spotters for wounded men in the field.

It is a well-known and generally recognized fact that a war dog must be in the "pink" of condition, both mentally and physically, at all times. If the special senses and preceptions which make the dog so valuable to the

Army are impaired, his value and usefulness are seriously affected. To maintain these dogs at a high peak of efficiency, a definite and workable plan was devised by the U. S. Army Veterinary Service. The main objective of the plan of the U.S. Army Veterinary Service pertaining to the War Dog Program consisted in establishing measures for the pervention and control of animal diseases that would cause animal inefficiency or might be transmitted to troops, as well as medical and surgical treatment to individual dog patients. There were four (4) diseases of dogs that became of considerable military significance with the institution of the War Dog Program. These diseases were: rabies, canine distemper, canine leptospirosis, and canine filariasis (heartworm). Rabies and leptospirosis are transmissible to man. Canine distemper and canine filariasis are highly infectious among dogs, one being readily controlled by vaccination and sanitation and the other being very difficult to control. The control of these diseases in overseas theaters presented a far more difficult problem than in the United States. For example, war dogs obtained from civilian owners in the Hawaiian Islands and trained by the Army, were not immunized against rabies because this area is one of the few rabies-free countries in the world. It is known that rabies is prevalent in all countries except England, Australia, New Zealand, and the Hawaiian Islands. In many overseas theaters, our war dogs were exposed to other communicable diseases which do not exist in this country. Likewise, in many foreign countries where our war dogs were used, there is no system of control for the many prevalent and highly contagious diseases of dogs. These war dogs were loaned, or donated, to the Army, by civilian owners and represented not only a financial investment, when trained, of not less than two-million dollars ($2,000,000) but also proved to be a valuable asset to war objectives of the nation and contributed materially in the successful accomplishment of our mission - to defeat the enemy.

The establishment of new foci of infection of canine filariasis, canine leptospirosis, and other canine diseases in the United States at the time of demobilization and return of dogs to their original owners presented a veterinary and public health problem of national importance. Many animals recover or can be successfully treated for these diseases, but some continue to be infected and spread the disease. Only those war dogs which had been proven, by the latest and most scientific methods, to be free from infectious and communicable diseases, were released to their civilian owners by the Remount Service which was responsible for deprocessing and detraining. Through the application of sound, time-proven principles of military preventive veterinary medicine, it was possible to avert a spread of diseases to our canine population, which would have jeopardized the health of our civilian population through the introduction of diseases unknown in this country.

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ARRIVALS, OFFICE OF THE SURGEON GENERAL

COLONEL BENNIE A. MOXNESS, MC, of Washington, D. C., formerly of Separation Center, Fort George G. Meade, Maryland, assigned to Physical Standards Division, Disposition & Retirement Branch.

1ST LIEUTENANT JULIUS G. COHEN, MC, of Burlington, Vermont, formerly of Fitzsimons General Hospital, Denver, Colo., assigned to Physical Standards Division, Induction & Appointment Branch.

1ST LIEUTENANT IRVING HOFF, MC, of Holyoke, Mass., formerly of Fitzsimons General Hospital, Denver, Colo., assigned to Physical Standards Division, Induction & Appointment Branch.

DEPARTURES, OFFICE OF THE SURGEON GENERAL

COLONEL WILLIAM B. FOSTER, MC, of Birmingham, Ala., formerly of Historical Division, Administrative Branch, assigned to Panama Canal Department, Quarry Heights, Canal Zone.

MAJOR ELMER C. RIGBY, MC, of Idaho Falls, Idaho, formerly of Office of Personnel, Overhead, assigned to Military District of Washington, General Dispensary, Pentagon, Washington, D. C.

PROMOTIONS, OFFICE OF THE SURGEON GENERAL

1st Lieutenant to Captain

RODERICK K. MORT, MAC, of Niagara Falls, New York, of Office of Personnel, Military Personnel Division, Assignments Branch.